EXHIBIT J

UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF TENNESSEE

CASE NO. 3:19-cv-00041

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SCOTT ALLEN TOMEI, :

Plaintiff, :

vs. :

PARKWEST MEDICAL CENTER and :

COVENANT HEALTH, :

Defendants.:

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DEPOSITION OF MARIE PATTERSON WILSON

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I N D E X

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(No Exhibits Marked.)

D E P O S I T I O N

The deposition of MARIE PATTERSON WILSON, taken at the request of the Plaintiff, for purposes of discovery, pursuant to the Tennessee Rules of Civil Procedure on the 18th Day of December, 2019, at the offices of Arnett, Draper & Hagood, LLP, 800 S. Gay Street, 2300 First Tennessee Plaza, Knoxville, Tennessee 37901 before Catherine Golembeski, Registered Professional Reporter and Notary Public at Large for the State of Tennessee.

It is agreed that the deposition may be taken in machine shorthand by Catherine Golembeski, Licensed Court Reporter and Registered Professional Reporter and Notary Public, and that she may swear the witness and thereafter transcribe her notes to typewriting and present to the witness for signature, and that all formalities touching caption, certificate, filing, transmission, etc., are expressly waived.

It is further agreed that all objections except as to the form of the questions are reserved to on or before the hearing.

EXAMINATION

(Proceedings began at 10:22 a.m.)

MARIE PATTERSON WILSON,

called as a witness at the instance of the Plaintiff, having been first duly sworn, was examined and deposed as follows:

EXAMINATION BY MR. ROZYNSKI:

Q. Good morning.

A. Good morning.

Q. My name is Andrew Rozynski. I'm with the law firm of Eisenberg and Baum. And I represent Scott Tomei in the matter against Parkwest. I brought you here to take your deposition.

Have you ever had a deposition taken before?

A. I have not.

Q. Since this is your first time, I'm going to go over some of the ground rules so we have a smooth deposition.

As you can see, the court reporter is taking down everything that we're saying. She's making a transcript. She's also sworn you under oath, which means you swore to tell the truth. And if you knowingly say anything that's false, that it could be subject to penalties. Okay?

A. Okay.

Q. So, also, it's really important that we have a clear record, since she is making a transcript, so that we have clear questions and answers. Sometimes you might know the question that I'm about to ask, but I just ask that you hold off on your answer until the question is complete so that the transcript would have a clear question and an answer. I'll wait until I ask my next question once you finish your answer. Okay?

A. Okay.

Q. There's also other things that do drive court reporters crazy like saying uh-huh, uh-uh, shaking your head, nodding your head instead of giving a verbal response. So I just ask that you give a verbal response to whatever question that's pending. Okay?

A. Okay.

Q. Also it's not a memory test. If you don't remember it's okay to say you don't remember. I do want your best recollection. So it's important that you give that. So, for instance, if I ask you a question about when something happened, and you recall it happened in October of 2017 but you don't know the exact date. Instead of saying I

don't remember when that happened, just give your best recollection. Okay?

A. Okay.

Q. I don't expect this to be a long deposition, but if you need to take a break at any time let me know and we'll take a break, just not in the middle of the question. Okay?

A. Okay.

Q. So please state your full name and address for the record?

A. Marie Paterson Wilson, 9200 Brandywine Circle, Knoxville, Tennessee 37922.

Q. And who's your current employer?

A. Parkwest Medical Center.

Q. How long have you worked for them?

A. Three years in September. I started in September of 2016.

Q. Okay. And what is your current title there?

A. RN or registered nurse.

Q. Okay. And what are your general job duties as a registered nurse?

A. I take care of patients on the floor. I execute doctor's orders as far as medications that they need to be given. I assess my patients.

I educate my patients. I chart on my patients a lot. I work with other nurses and nursing assistants on the floor.

Q. Have you ever had a patient who only spoke Spanish?

A. Not only Spanish. I have had patients who Spanish is their first language, but they've been able to speak to me in English.

Q. Okay. Have you ever had a patient who only spoke another language?

A. Not only another language, no. They've -- all of my patients that I've had have been able to speak some English to me.

Q. Are you trained in any way that if someone's primary language is a language other than English, to insure that they have an interpreter?

A. Yes. We have an education system through Covenant where we're taught how to use the video conferencing system, to get an interpreter if we need to.

It's also my understanding that we can ask for or request, you know, physical interpreters for patients who speak other languages.

Q. Okay. And are you trained that if someone identifies as their primary language

something other than English, that you should do all communications with them in their language -- in there primary language?

A. I'm trained to -- I'm trained to help the patient as best I can. And if they request or let me know they need another form of communication, then I can follow through with that or if I feel that I'm not able to communicate with them what I need to communicate, then I can go those other avenues.

Q. Okay. So you're not trained that you should communicate with someone, if someone identifies as their primary language is something other than English, that you should always communicate with them in that language. You're not trained on that?

A. We're trained to communicate with them in the way that they want to communicate. So if they specifically ask us to use another form of communication, then we're trained to accommodate them in that request. I don't make assumptions. I let them -- if we're able to communicate, then I let them tell me how they want to communicate. If I go into a room and they can't speak my language at all, then I'll go to other avenues.

Q. Okay. So just to be clear, you are not trained to communicate in someone's primary language once they've identified that their current language is something other than English for all communications?

MR. YOUNG: I think it's been asked and answered.

You may answer.

A. Okay. I'm sorry. I'm trained that if a patient can not communicate with me and requests another form of communication, I accommodate that request or do everything I can to accommodate that request.

Q. So my question has nothing to do with accommodating a request. My question was: If someone identifies as a primary language other than English, are you trained to communicate with them every time through that primary language? That's a yes or no or if you can't answer yes or no.

A. I'm trained to communicate with the patient how they ask to be communicated with.

Q. Okay. So identifying as a primary language, I just don't understand, because if someone primarily communicates in another language other than English, how can they tell you that?

A. They would -- I would know that because I wouldn't be able to communicate with them. If I say, can you tell me how you're feeling? And their face is blank, they don't understand me at all, and I can't communicate with them, then I'll go down the avenues of other forms of communication working with the video system or other things.

Q. Have you heard of a communication assessment tool?

A. I don't know that we -- I don't know that I have.

Q. Okay. Have you ever filled out a form where you present it to someone who speaks a language other than English where they fill it out and make a request about what kind of accommodations they may need?

A. I haven't had to fill out a form like that, no.

Q. Are you aware if any exists?

A. We do, I believe, have a form on the floor. I've seen other nurses fill one out where they need to go to other routes of communication.

Q. So that form is only filled out if a nurse feels like there should be other routes of communication?

MR. YOUNG: Object to the form.
You may answer.
A. Oh, sorry. You know, I'm not sure. I haven't had to fill one out. So I feel like, I think, the nurse would fill that out if they felt like they were not able to effectively communicate with the patient.
Q. Is that based on assumption or based on what you know?
A. That's how we're taught. That's the process we're taught to go through when there are barriers to communication, but I haven't had to do it, so.
Q. So are you saying that if the communication tool form is filled out, that means that a nurse has a sense that someone can not communicate effectively in English so that an interpreter is needed?
A. That some sort of, yes, that would be my assumption, that some sort of interpretation may be required at times if that form is filled out.
Q. You said at times. What do you mean?
A. It's not always required. I mean, like I've told you about patients that I've had before, sometimes they're able to communicate effectively

in a language for the basis of the questions that you're asking. So if it's a simple yes or no question, if it's asking them, you know, to rate their pain level, you know, are you in pain? A lot of people can say yes or no to that or convey an answer to that without necessarily having to go through an interpreter.

Q. Okay. Are you trained on what the risks are of using family members as interpreters?

A. Yes.

Q. What are the risks?

A. The risk is that the family member might edit the questions that you're asking. They might edit the patient's response. So usually it's best to have a non-biased interpreter.

Q. And also there's no way -- are you trained that there's no way of assessing if they have the sufficient medical terminology to be able to communicate with the patient?

A. Yeah. I mean, there's no way to know what their background is or if they have medical terminology to communicate to the patient.

Q. Did you review any records to prepare for today?

A. Yes.

Q. What records did you review?

A. I looked at my charting.

Q. How many pages of charting did you review, approximately?

A. It was probably 10 maybe.

Q. Okay. Do you know who Scott Tomei is?

A. I do.

Q. Do you have a memory of him?

A. I do have a memory of him.

Q. And is he a deaf man?

A. Yes.

Q. Do you understand that he communicates in sign language?

A. Yes, primarily.

Q. Okay. And during your time with Mr. Tomei, did you ever use a professional sign language interpreter?

A. Not to my knowledge. There was someone in the room with him who was able to translate, as far as I know, they were not a professional, but I don't know that to be certain.

Q. So do you know who these people were in the room?

A. Not by any introduction or introduction that I remember in the room.

Q. Okay. So you don't know if this was a stranger, friends, family, somebody else?

A. I don't know their relationship to him. I assumed they were family because he, obviously, wanted them in the room with him. But I didn't get an introduction or a name that I recall.

Q. Did you assess the abilities of the person that was in the room signing to Mr. Tomei?

A. Not that I recall. I don't remember doing that.

Q. And did you see Mr. Tomei on October 24, 2017 admission to the 27th, 2017 admission?

A. I believe I had him on the night of October 26th, so that's kind of in between there.

Q. Okay.

A. I took care of him starting at about 6:45 to 7 p.m. on the night of the 26th through the morning of the 27th.

Q. I'm going to hand you what's been previously marked as Exhibit-1. It's the medical records. Can you show me where your notes are in this?

(Witness complies.)

A. This may take a while.

Q. Sure.

MR. YOUNG: Do you want her to review the whole chart?

MR. ROZYNSKI: Yes.

MR. YOUNG: I think we have a several hundred page chart here. And she's being asked to make sure every single page in which her name may appear. I think it's unfair on that basis.

Q. What page are you on?

A. 90. I can't be sure that there's nothing I've missed, but I have not seen -- I'm looking for what I know the pages look like that have my charting on them and I've not found them.

Q. You're still looking? You found something on 90?

A. There's my name. That would be his rhythm strip.

Q. What page is that on?

A. 92.

Q. Okay. As you see them, just let me know.

A. There's my initials on his medical -- on his MAR, where we administered medications. So he had medicines from me at 21:30 on the 26th and at 4:16 on the 27th.

Q. Okay.

A. And also at -- it just says times two. There's my initials, yes, 21:30, 23:35, 2:08 and 4:16 for medication administration, morphine.

On page 113 here's my name.

Q. Okay. So on 113 at 10/27 at 5:47 a.m., you say the patient is deaf?

A. Yes.

Q. Okay. And the whole outcomes and goals, it says communication. Did you write that in?

A. I did not write that in. This is -- we have a click system for palliative care where you tick off a nursing diagnosis and the goals. Honestly, this is an old system. We don't have this system any more, so I don't remember. It's not -- you don't write anything in, you can tick off a goal, as well as ticking off the nursing diagnosis.

Q. Did you tick off improve communication in the nursing diagnosis?

A. According to my charting, yes. This would have been -- I'm sorry. Nursing notes is impaired communication.

Q. Okay. Do you know why you ticked off impaired communication for Mr. Tomei?

A. Because he was deaf.

Q. Okay. Do you know if he could lip read, or write or something else?

A. I don't know. I don't remember.

Q. Okay. So when you have a nursing diagnosis of impaired communication, how do you -- how do you improve the communication as an outcome or goal?

MR. YOUNG: I object. I think it could misstate prior testimony.

A. Can you repeat the question? I'm sorry.

Q. So nursing diagnosis said impaired communication, correct?

A. Yes.

Q. And outcomes and goals it says communication?

A. Yes.

Q. So is the outcome and goal to improve communication?

A. The outcome or goal is to have sufficient communication with the patient.

Q. Okay. The interventionist team, POC, what does that mean?

A. Team palliative care.

Q. Does that have anything to do with having communication?

A. I don't remember his specific plan of care.

Q. Okay.

A. That's all I can say.

Q. Do you know if you provided a video interpreter to Mr. Tomei?

A. I do not remember providing a video interpreter to him.

Q. Okay. Would the palliative care be somewhere in his chart for this communication improvement or impairment?

A. Yeah, I guess it could be.

Q. All right. Well, let's keep on going to where your entries show up.

A. Page 116.

Q. Okay. So speech, you write patient is deaf. What does that mean? What does that have to do with his speech?

A. It just says that he's deaf.

Q. So why does it say speech there?

A. That's just where I entered it in on the chart.

Q. Do you know if his speech was impaired

or not?

A. I don't. I'm sure -- I'm trying to remember if he spoke. I don't remember him -- I feel like I spoke some, you know, that he was able to nod or, you know, make affirmative communication to me, but I can't recall the specifics of his speech.

Q. Okay. Do you have any other entries on this page?

A. I mean, this whole page, this is the assessment that I charted on him.

Q. Okay. So speech, it says garbled. Did you write that?

A. Oh, yes.

Q. So he didn't have clear speech?

A. Not according to my charting.

Q. Is that a response to voice? Does that mean he could hear?

A. Yeah. I mean, I did tick voice and touch, but it's my understanding that he can not hear.

Q. Okay. So there's a Glasgow Coma score?

A. Uh-huh.

Q. Best verbal five. What does that mean?

A. That means that the patient is

oriented. It says oriented slash verbalize, but oriented. You're able to assess that they know where they are.

Q. So did he verbalize that to you?

A. I don't remember him verbalizing it, but you can't separate the orient from the verbal. It's just a tick in the chart. So I would have ticked that he was oriented and that he knew where he was.

Q. So was he obeying verbal commands from you?

A. Not from me, but there was a companion in the room that when I was doing my assessment and I would ask him to, you know, squeeze my fingers, look this way, he was able to do those things through the companion that was interpreting.

Q. So the companion wasn't verbalizing to him?

A. I think he was signing. He was signing with the woman in the room.

Q. The gentleman that was there was a companion who was signing?

A. It was a female.

Q. Okay. Where else are you? Are you on the next page?

A. Yes.

Q. How about on the next page?

A. Yes.

Q. So the education, we're on page 118, right?

A. Yes.

Q. Education: Teach back, patient and family discussed?

A. Yes, that's what it says.

Q. How did you do teach back with Mr. Tomei?

A. So this is on our fall risk assessment. So it's, basically, saying that you educated the patient and the family on the level one interventions for a fall. So that the side rails are to remain up, that they're oriented, that they know where their call light is, belongings are in reach, things like that.

And then the education part is how you know that they understood that, and that they are able to understand what you've talked to them and they could say affirmative to yes will do these things.

Q. Do you know how he did that from your memory without looking?

A. From memory, I would assume that my main recollection of Mr. Tomei is communicating through the companion in the room that was signing.

Q. Did you ever ask Mr. Tomei if he ever wanted a professional interpreter?

A. I do not recall asking him if he wanted one. He never asked me for one, but I don't remember asking him if he wanted one.

Q. Okay. Is the protocol at Parkwest to not offer an interpreter, but to wait for one to be asked for?

A. I'm not certain of the specific protocol.

Q. Is it your understanding that you should only wait for a request rather than offer an interpreter?

A. I'm trained to, if I'm able to effectively communicate what I need to, then I'm trained to do that. But if I feel that the communication is ineffective, then I can go down the routes of working in some of those tools or at any time if the patient asks me to use those tools.

Q. Okay. Let's go to page 120. It says 10/26/17 at 21:12, emotional status PMW. Is that you?

A. Yes.
Q. Patient unable to communicate as he is deaf.
A. Uh-huh.
Q. Is that what it says?
A. Yes.
Q. And you wrote that?
A. I typed it in.
Q. You typed that in?
A. It looks like it, yes.
Q. Okay. So it was your assessment that you were unable to communicate with him because he's deaf?
MR. YOUNG: Objection. Misstates question.
Go ahead and answer.
A. I was able to communicate with the patient. I should have, you know, put verbally communicate with me, but I felt like I was able to communicate with him.
Q. So you would have written that patient unable to communicate as he is deaf if, in fact, you could communicate with him even though he was deaf?
MR. YOUNG: Same objection.

A. I should have added verbally communicate, you know, as in speech.

Q. What's emotional status assessment?

A. Just where you are assessing the patient's emotional status.

Q. And is that by asking him questions?

A. Usually not. It's usually by observing the patient, seeing if they're distressed, if they're happy, sad, in pain.

Q. When you do an emotional status assessment, you don't ask a person how they're feeling or if there's anything bothering them, or if they feel any stress or anything? You never ask that for patients?

A. Yes, yeah.

Q. You do ask that of patients?

A. It comes out through the questioning in other parts of your assessment. You're asking them how they're feeling, if they have pain.

Q. Okay. Were you able to do that with Mr. Tomei or were you unable to do that because he's deaf?

A. I was unable to get a verbal response from him due to his deafness and his level of speech. But that doesn't mean you can't still put

down what you assess as emotional status. As I said before, sometimes you can do that by observing the patient, plus seeing their demeanor, if they're coping.

Q. But you didn't put anything about what your observations were in your emotional status assessment, right?

A. It does not look like I did.

Q. Okay. So you were not able to ascertain either by observation or communicating with Mr. Tomei?

A. According to the chart it says other. And then just, you know, just the comment that he is deaf.

Q. And that you're unable to communicate with him.

MR. YOUNG: Objection. Misstates prior testimony.

Go ahead.

A. It says patient unable to communicate, not that I was unable to communicate with him.

Q. Okay. So if he can't communicate with you, isn't communication a two-way street?

A. Yes. And as I said earlier, I should have typed in verbally as well, but I did feel that

we were able to communicate.

Q. Okay. So when you put other for emotional status, that allows you to do free text?

A. Yes.

Q. And so you put other. And then you put free text, patient unable to communicate as he is deaf?

A. Yes.

Q. So you could have ticked off your observations, but you did not, right?

A. It appears that way, yes.

Q. Okay. Do you have a specific recollection of your interaction with him during this emotional status assessment?

A. Not necessarily at 21:20 exactly, but I have a recollection of his emotional status throughout the night, yes.

Q. So if you assess that Mr. Tomei can not communicate with you verbally, did you offer him an interpreter?

A. I don't remember offering him an interpreter, because I felt I was able to effectively communicate the answers that I needed, for what I needed to do that night through his companion who was signing with him.

Q. Okay. So even though you are unable to do an emotional status observation of Mr. Tomei, you still -- and you noted that the patient is unable to communicate as he is deaf, you still felt like you could communicate with him?

MR. YOUNG: That partially misstates partial testimony.

Go ahead.

A. I felt I could communicate with him and assess his emotional status that night.

Q. But that's not noted in your record.

MR. YOUNG: Objection.

A. No.

Q. Okay. And are you trained by Parkwest that if you're unable to communicate for any reason that you should offer an interpreter?

A. Yes. If we're unable to communicate effectively, we are trained to offer some of our translating tools.

Q. Okay. And would you agree there's no offer of an interpreter in this note?

A. I do not remember offering him an interpreter.

Q. Okay. Where else is your entries? I'm sorry, entries?

A. 121.
Q. Okay.
A. 122.
Q. All right.
A. 123.
Q. Okay. So let's go back to 123. At 10/27/17 at 2:35 it says: "Patient pain worsening and meds are not relieving pain. Patient very uncomfortable. VS stable." What does VS mean?
A. Vital signs. And, yes, that's what it says. That's the note from 2:35 a.m. on 10/27.
Q. So Mr. Tomei was still struggling with uncontrolled pain at four milligrams of morphine?
A. Yes.
Q. Does that indicate to you that Mr. Tomei was in a lot of pain?
A. Yes, absolutely, he was in a lot of pain.
Q. Did you ask Mr. Tomei to describe his pain?
A. I don't remember asking him to describe it. It was obvious to me that he was in a lot of pain.
Q. How was it obvious?
A. He was very -- my memory of him that

night is him being extremely uncomfortable, you know, just restless in the bed, you know, complaining, moaning, he was very uncomfortable.

Q. Okay. Where else does your name pop up?

A. It's page 125.

Q. Okay.

A. Page 126.

Q. All right.

A. 127.

Q. Okay.

A. 128.

Q. So Mr. Tomei had an order for Dilaudid?

A. Dilaudid.

Q. And what is that?

A. It's a pain medication.

Q. Is that stronger than morphine?

A. Yes.

Q. Do you know why he was prescribed that?

A. Because I contacted the doctor during the night because the morphine was not controlling his pain. So I called and got an order for Dilaudid, it looks like at 5:14 a.m..

Q. Okay. Where else in the chart?

A. I only took care of him on the night of

the 26th and into the early morning of the 27th.

MR. YOUNG: Do you mind if I step out while she's doing that?

MR. ROZYNSKI: Sure.

Q. If you find any other pages just put it off to the side.

(A recess transpired.)

Q. Okay. You said 198?

A. Yes, I see my initials. It looks like. I'm not familiar with the way this page is laid out, but it looks like it's for when I put calls into the doctor to try and get additional pain medications ordered for him. And it's got the note from 2:30 and from 4:38.

Q. When a patient is in that much pain, is the only important thing to ask the patient, what is your pain level from zero to 10?

A. I wouldn't say that's the only important thing. It's certainly the most important.

Q. Okay. Are there other things you typically ask patients who are in a lot of pain, other than tell me from zero to 10 what your pain level is?

A. I mean, you can ask them other things

about their pain, but if they're able to give you a number and show you where or indicate where they're hurting, that's the most important part of the assessment.

Q. What other questions do you ask about pain, other than what is your pain level from zero to 10?

A. You can ask when did it start? Have you been having it for a while?

Q. How about where is the pain coming from? Is that something?

A. Yes, that's something.

Q. Is it a dull pain or sharp pain?

A. You could ask those questions, yes.

Q. Is the pain spreading?

A. We ask the location of the pain and how long it's been there. And so if they're able to indicate that it's going to other places, then yes.

Q. Is that important to know if it is spreading or getting worse in other places?

A. Yes.

Q. Could that indicate that the condition is getting worse if the pain is spreading to other places?

A. It could indicate a lot of things. It

could indicate there are other issues. It could indicate referred pain, but yes.

Q. Okay. So that could help diagnose other ailments if you know that the pain is spreading to other places?

A. If you know that they're having pain in other places than what they've first identified, yes.

Q. So there are questions or inquiries of value when someone has pain, other than what's your pain level other than zero to 10?

A. Yes.

Q. That can assist in having better treatment for a patient?

A. Yes.

Q. And is it helpful for the patient to be able to describe it in detail, their pain?

A. It can be.

Q. On page 202, 10/27/17 at 2:35 a.m., interventions BMW?

A. Yes.

Q. Attempting to call physician for vascular surgery?

A. Yes.

Q. What does that mean?

A. That means that I would have called their on- call pager. And waiting for a call back.

Q. Is this just to get orders for stronger pain medicine or are you asking for surgery at this time?

A. Well, his admitting doctor was in the vascular surgery group. So I was calling the on-call physician for the vascular surgery group, is what that means. So I was just attempting to contact whoever was on call for the attending physician. And it's my recollection that I was calling to inform them of the level of pain that Mr. Tomei was having, and that the current pain medications were not giving him adequate pain relief.

Q. Is there anything stronger than Dilaudid?

A. Dilaudid.

Q. Dilaudid?

A. Yes, but not that we give on the floor.

Q. Okay. What is Dilaudid the strongest that you can give on the floor?

A. It's the strongest that I've given on the floor. I don't know that I would say it's the strongest that can be given on the floor, but it is

certainly a step up above morphine.

Q. What are the typical cases that you're aware of that you've given Dilaudid for?

A. We give Dilaudid for vascular patients. We give Dilaudid for patients who have an allergy to morphine. We give Dilaudid, I'm trying to think.

Q. How about burn victims?

A. I've never taken care of a burn victim.

Q. Okay. What other types of vascular cases that you have given Dilaudid?

A. Where there's just, like, where there's a blood clot obstructing blood flow, that's usually -- that's the most common case that I've given.

Q. Was Mr. Tomei given Fentanyl?

A. Not by me.

Q. Is Fentanyl a step up from Dilaudid?

A. Yes.

MR. YOUNG: Object to the extent that it may call for an expert opinion for which I'm not sure this witness has yet been established as.

You may answer to the extent you know.

This is, obviously, beyond any 30(b)6 testimony.

A. What was the question again?

Q. Is Fentanyl a step up from Dilaudid?

MR. YOUNG: Same objection, but you can answer.

A. To my understanding it is. I've never given Fentanyl. It's usually given in the PACU, like, post surgical patients. And those orders are always discontinued by the time the patient would arrive on the floor of my unit.

Q. Has your name popped up anywhere else?

A. Yes, 232.

Q. What's that?

A. It looks like this is his list of orders for his diet, for his lab work, for his medications. So this would have been just me confirming his order set. So it's just got me listed up at the top there. This continues with just all of his orders, more lab work. My name is just at the top of all of them because I confirmed his orders. Here's an order for Dilaudid. It has me at the top of all of those pages as far as confirming those orders. And the last page is 238.

Q. Okay. And then it starts the day shift nurse. Was there anything that you reviewed in your preparation for today in terms of medical records that you haven't already seen?

A. I don't know.

Q. Anything that stands out to you, anything of significance?

A. No.

MR. ROZYNSKI: I don't have any other questions. Thank you.

MR. YOUNG: I'm going go to step out with Devon and I'll decide whether I want to ask any questions.

(A recess transpired.)

MR. YOUNG: No questions.

(Deposition was concluded at 11:29 a.m.)

C E R T I F I C A T E

STATE OF TENNESSEE

COUNTY OF KNOX

I, Catherine Golembeski, Licensed Court Reporter and Registered Professional Reporter, do hereby certify that I reported in machine shorthand the deposition of MARIE PATTERSON WILSON, called as a witness at the instance of the Plaintiff, that the said witness was duly sworn by me; that the reading and subscribing of the deposition by the witness was waived; that the foregoing pages were transcribed under my personal supervision and constitute a true and accurate record of the deposition of said witness.

I further certify that I am not an attorney or counsel of any of the parties, nor an employee or relative of any attorney or counsel connected with the action, nor financially interested in the action.

Cathy J. Golembeski

Catherine Golembeski, LCR# 778
Registered Professional Reporter